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Review Article

So You Think You Are Not Losing Money in Your Practice

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This is a summary article for physicans, provider, and staff to summarize basic pitfalls in revenue cycle management. Its intent is to increase utilization of current systems such as EMR while increasing efficieny through the creation of standardized operating procedures.

While no one wants to believe that his or her practice management strategies lose money, experience shows us that two of the biggest pain points in a medical practice in 2022 are the underutilization of electronic medical record (EMR) tools combined with ineffective billing/coding management procedures. In this article we discuss what to check for in your current usage and offer some prescriptive measures to improve profitability.

Whether you manage all coding, billing, and receivables internally or you outsource much of this activity, it's important to understand that systems and training are your friends.

a Nicola Hawkinson, DNP, RN, RNFA received her Bachelor of Science in Nursing from the University of Delaware. Upon graduation Nicola began her career as a Registered Nurse by being accepted into Lenox Hill Hospital's first operating room nurse intern program. After successful completion, she continued as an operating room nurse specializing in orthopedics and general surgery for approximately three years.

The operating room transformed Nicola from a novice nurse to an expert. During this time Nicola gained vast knowledge of surgical procedures, anatomy, techniques, and instrumentation while functioning in a highly autonomous role where time management and critical thinking is paramount. Simultaneously, Nicola was accepted to New York University's adult acute care nurse practitioner program and began her Master's study.

Realizing that prior to graduation as a Nurse Practitioner gaining what in nurse's lingo is called floor experience would be an asset, Nicola accepted a position as a Registered Nurse at Memorial Sloan Kettering Cancer Center in thoracic surgery. Unlike her operating room experience, Nicola learned how to manage a heavy patient load and prioritize tasks. The patient population consisted of both surgical and nonsurgical patients. During this time Nicola became certified as a chemotherapy nurse. Nicola's operating room experience was beneficial is caring for post-operative lung patients. Medical patients, primarily terminally ill and chemotherapy patients, taught Nicola a new skill set, caring for patients and families during end of life.

Upon graduation, Nicola became certified as an adult acute care nurse practitioner. She accepted a position working in collaboration with two orthopedic surgeons, Dr. Frank Schwab and Dr. Ronald Grelsamer. Nicola quickly became knowledgeable about the spine, knee and hip. As the first nurse practitioner to join this large orthopedic group, Nicola was able to educate the group about the role of the nurse practitioner while gaining vast experience in the assessment, diagnosis and treatment of orthopedic patients. For surgical patients, Nicola served as a true patient advocate, educating the patient with regard to preparing for surgery and continued support throughout the postoperative period. Simultaneously, Nicola maintained her relationship with New York University as an Adjunct Clinical Professor in the Master's program. As the practice continued to grow, a second nurse practitioner joined the practice, and Nicola focused her career on the treatment of patients with spinal conditions.

In an effort to advance, Nicola became certified as an RNFA (Registered Nurse First Assistant) enabling herself to return to the operating room (where she began) and help assist in spinal surgeries. In addition she was asked to join the editorial board of Spine Universe, frequently writing articles and continuing education tutorials. Believing that it was of the utmost importance to educate herself to the highest level Nicola was accepted into Case Western Reserve University's doctorate of nursing program, and completed her dissertation in June 2010. Nicola is an active member of the North American Spine Society, and serves on the Allied Health Section Committee.

Since 2008, Nicola has served as the CEO/ Founder of SpineSearch, a full service recruitment, education and consulting company dedicated to orthopedic spine surgeons, neurosurgeons and pain management physicians. SpineSearch is based in New York City and services hospitals, ambulatory centers and practices nationwide.

Visit the SpineSearch Website

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Conflicts of Interest Statement for Nicola Hawkinson

FIVE PITFALLS OF MEDICAL BILLING

1. NOT UNDERSTANDING THE FULL CAPACITY OF YOUR EMR

Your EMR is undoubtedly expensive and your EMR provider has built in multiple features which are intended to make for a more effective tool. Modern EMRs are chock full of useful features that can improve the profitability of a practice. Have you reviewed your EMR manual, and are you using all of its features?

Use all messaging features to improve communication between providers and administrative staff. Your providers should not be tasked with administrative tasks than can easily be delegated. Effective use of your EMR can also assist in making sure that medical assistants are performing at the top of their license by following up on alerts and reminders before the provider sees the patient.

Be sure to set up any and all useful automations that are included with your EMR. For example, many systems include a variety of automated appointment reminder functions. No-shows are an insidious cost to your practice. EMRs can generate emails, text messages, and other notifications for patients and/or scheduling staff. Reducing your practice's no-shows increases revenue.

Other automated features may prove useful in reducing the overhead involved in prescription renewals, scheduling of follow up visits, and other recurring events.

Another often underutilized capacity is in the area of reporting. Reports can inform you of unreviewed and/or new imaging. Many practices use reports designed to schedule follow-up or health maintenance care.

You can also run canned or custom reports that will tell you exactly where the practice is in terms of cash flow, receivables, bad debts, etc. Reports can generate hit lists of required follow up where insurers or payors may have failed to keep agreements.

We recommend you run major reports daily. In 2022, it is inexcusable to be unaware of the financial health of your organization and its outstanding receivables.

2. THE IMPORTANCE OF CLEAN SCRUBBED DATA

Accuracy of your records is critical. If you fail to properly record billing data or the information that supports use of a particular billing code, your insurance claim is going to be "DENIED."

No one at the insurance company will be doing error checking for you, and no one is going to tell you that you were denied because you misused billing code xxxxx. Your claim is simply denied, and even if you ultimately make the necessary corrections and receive payment, you've slowed your account receivables process and had to dedicate administrative and often provider resources to figuring out why the claim was denied in the first place, and to making corrections.

Get it right to begin with and your practice will be more profitable. Clean data makes it more likely that you get the claim right to begin with, or more simply put:

Clean Data = Rapid Payment

Clean data also simplifies the appeals process in the unlikely event that you find yourself battling over payment (despite your best efforts to assure that your data is accurate). Consider these versions of the same scenario.

Your claim is denied because the necessity of the procedure is disputed.

Scenario 1 – Your reply is that you will get the imaging together and discuss it with the provider. You will re-submit with the new information and await results.

Scenario 2 – You reply that the rationale for the procedure is discussed in the operative and diagnostic notes (which the insurer has in their possession).

3. HAVING STANDARD OPERATING PROCEDURES (SOP) TO DEAL WITH CLAIM DENIALS AND APPEALS

If you're billing insurance companies or the government for provision of medical procedures, you will have claims denied. This shouldn't surprise you, and it absolutely should not result in a question of "What Do We Do Now?"

A denial rate in excess of 5% does require analysis and corrective action. If you're in the 1-2% range, we think you've probably implemented most of the programs we've

described here. If you've never had a claim denied, there's a possibility you may be under-billing.

Your internal systems should be focused on the importance of getting an appeal letter out within 24 hours of the original denial, and planning for a call to the insurance manager who handles your practice.

Schedule the stages in following up on denial and appeals. When will your appeal go out? Who prepares the appeal? Who reviews the appeal? How long will you wait for a reply? If the reply is still negative, what do you do next?

We use SOPs so that we are not "re-inventing the wheel" every time there is a glitch in a claim.

Can you imagine the chaos if a patient and the operative team arrived in the OR with no knowledge of whose responsibility each task was? Who positions the patient? Who will do anesthesia? Who's monitoring, and what are the norms? We use SOPs in the OR because it's better that way.

That is equally true in the area of dealing with denials and appeals. SOPs are your superpower in improving the likelihood that you will be successful in presenting your case. They ensure that your entire team is working systematically and coherently towards a successful outcome, and that no team member "goes rogue" by making agreements or following tactics that aren't within the scope of your SOP.

You should also have a standard operating procedure for getting the patient involved. Insurers much prefer it when the nitty-gritty of denials and appeals are invisible to the patient. In the vast majority of cases, your patient will be at least slightly embarrassed that their insurer has denied the claim, will be on your side, and will also be concerned they will end up owing the denied amount.

A patient with a good outcome can be one of your best allies in the appeal process.

4. CODING

We cannot overemphasize the importance of thorough operative notes. Some providers have a near supernatural ability to recall detail of surgeries and procedures. Others do not.

Either way, thorough operative notes help to maximize revenue and minimize delays.

The failure to provide robust operative notes leads directly to underbilling. An experienced and well-trained coder will review operative notes and spot the opportunities to choose the most beneficial codes and supplemental codes. They will also know how to use the operative notes to provide necessary validation for all billing codes that are used in the claim.

Robust operative notes also reduce the chance of claim denial and improve the likelihood of a successful appeal. In some cases, the provider might be able to provide more detailed information from their memory of the procedure. However, you cannot count on this, and you may end up in a situation where the provider simply can't remember. The lack of information leads directly to an inability to appeal successfully.

To state the obvious, you cannot guess as that might lead directly to unpleasant legal consequences. Your potential for a successful appeal is greatly enhanced when you can simply cite the original, and complete operative notes.

Note that we mentioned the use of all EMR features as our starting point. Many current EMRs offer cues and hints based on the entries you make. Enable this feature if available in your own EMR system and use it to your advantage.

5. NEGOTIATIONS, REFUNDS, AND COMPLIANCE

Remember that you need to be in compliance with your insurer agreements. Have a clear understanding of the agreements you have signed. In some cases, it's far too easy for an insurer to deny a claim because you've been slow in filing; or alternatively insurers may design their agreements to automatically exclude appeals after a certain amount of time has elapsed.

Timely submissions demonstrate compliance with your insurer agreement, and make it more difficult for insurers to suggest that you've failed to live up to your end.

This goes back to the importance of your standard operating procedures matching up with your obligations. Your stringent compliance with terms of your insurer agreements enhances your position during negotiations.

On occasion, you may find yourself acting as an out-of-network provider. Don't hesitate to seek out FAIR Health data to establish the statistical norms for the service to be provided within the relevant geographic area. Data and information are your best friends when negotiating with insurers.

Consider using social media as a part of your fee negotiation strategy. Some current EMRs integrate social media functions and/or are connected to online "doctor rating" services. Take the time to identify happy and satisfied patients with good outcomes and let them know that you would appreciate it if they would rate their provider and/or practice.

Be assured that numerous high ratings at RateMDs or on Google can have a positive impact on your ability to negotiate satisfactory rates with insurers. It's also worth noting that a larger number of positive reviews helps insulate you against the occasional poor rating that ALL practitioners sometimes receive.

Earlier, we mentioned that patients can be excellent allies in the appeals process. By encouraging previous patients to rate your practice, you are in fact turning them all into allies in the appeals process.

5 STRATEGIES THAT IMPROVE MEDICAL BILLING

1. CREATE A SUPERHERO

Identify a "superuser" of the EMR system. This person is provided with the time and authority to attend courses if appropriate, and at least some part of their time will be spent in formally learning the system you use.

Ultimately, the objective is that this person knows all of the EMR features and benefits and is in charge of training your other EMR users. And yes, we mean this person will be training the providers.

Although less common in today's medical environment, we still see occasions where certain MDs are unwilling to accept training from their employees, and other situations where employees feel uncomfortable in training senior medical staff.

That's just dumb. Your practice is successful when you maximize the contribution of all its members.

Additionally, your superuser will be responsible for contacting customer support for EMR IT-related issues. This is significantly more effective than having individual users contact support. Your superuser becomes the repository of knowledge learned by all of your users and all of your customer support contacts.

In addition to any possible financial benefits, consider attaching a formal title to this position. Titles can enhance the authority of your superuser and can also be beneficial in ensuring that recalcitrant providers and users recognize the value of the superuser concept.

It's important that your entire staff understands that the superuser is an asset to everyone, and a threat to no one.

2. DILIGENT WELL-TRAINED PEOPLE IN A QUIET SPACE

Realistically, the coding, billing, and receivables functions may be the most important part of your medical practice or facility. Let's face it. Without those functions in place, it doesn't much matter how talented your medical team is—you'll soon be out of business.

What that means of course, is that you need to treat that department with the respect it deserves. Hire or outsource carefully after fully reviewing the CV and background of prospective employees, or the professional bona fides of external providers.

Within your practice, it's important to support and fund ongoing training and experience opportunities for your staff. Encourage your team to join professional associations and assist them in taking advantage of courses and seminars presented by the associations.

Effective coding and billing is hard work and requires focus and concentration. Make sure that your team has a quiet, efficient, and dedicated space. If you think you're saving money by tucking them into a reception area where anybody can walk up and distract them by asking random questions, you are only kidding yourself—and you will end up paying for this false economy.

Instead, remember this truth. For the most part, employees who feel they are treated as valued team members behave as we expect valued team members to behave. That means an efficient and comfortable workspace should be considered mandatory.

3. DEVELOP THESE SOPS FOR THE OFFICE

SOPs make it easier to deal with both the routine and the unforeseen. There are many examples of SOPs that you might institute. Common examples are:

All fields on forms must be filled in or marked N/A. You'll need a standard frequency of billing to patients or insurance accounts.

How often will you review receivables aging reports? How many days before you reach out to patients or insurance on unpaid claims? A complete manual of standard operating procedures means that employees can manage almost all events within the scope of the Billing Department with no need to seek additional guidance.

All non-routine activities, events, and exceptions should be reviewed with your superuser and/or department leader.

Determine your SOP for moving accounts receivable to collections. How long? How many attempts?

Recurrent billing, EMR, or insurance problems will be reported to the superuser. Billing updates or procedure changes from outside agencies and third-party payers will be reviewed by the superuser and department leader as received, and changes communicated to the billing and front desk staff.

Billing staff and the superuser will be available to front desk staff as a resource to respond to questions about patient insurance coverage eligibility or related issues. The department leader should be available to review patient insurance eligibility with the front desk staff at the time of appointment.

Follow all requirements related the Health Insurance Portability and Accountability Act, and specifically add them to your SOPs to demonstrate compliance.

4. HAVE A SECOND CODER DOUBLE CHECK WORK

The simple act of having a second coder review work will improve your office efficiency, reduce errors, and improve teamwork.

When you implement this policy, it's vitally important that it applies to ALL coding, and equally important that the procedure is presented to the users as a team of equals working together. Don't make the mistake of having coder A submit "hard claims" to coder B, because coder B has more experience, or even having all claims double checked by a more senior coder. That actually sets up a poor work dynamic for your office.

The model you're building will have every claim reviewed by a 2nd set of eyes: coder A checks coder B, and coder B checks coder A. In this way, you still get all the benefits of having senior coders see complex claims, but it is structured in a way that increases the knowledge base of all the members of the team.

Your coders learn from each other's experiences, and you encourage the coders to discuss challenging cases.

5. HAVE STAFF AND MANAGERS STAY CURRENT WITH FEDERAL, STATE AND SOCIETY-BASED COMPLIANCE RULES AND REGULATIONS.

Let's repeat this: a successful practice emphasizes training, SOPs, systems, and compliance.

You must ensure that your team is current with and implements government rules and regulations, all of which should appear in your SOPs. Anything less is just careless, and leaves the practice exposed to claim denials, legal action, censure, and any number of potential problems.

Imagine that you want to pursue legal action against a patient or an insurance provider. In court, the defendant demonstrates that your practice doesn't follow regulations related to patients and billing. How do you think you are going to make out with your case?

Similarly, society recommended rules, regulations, and procedures do not gestate in a vacuum. Typically, they are the result of expert committees of the most experienced society members gathering to address known problems.

At a minimum, your adoption of society recommendations and regulations typically results in "best-practice" systems within your own organization. In most instances, your staff will obtain training through the relevant society, and you will end up with better trained staff who are implementing gold standard procedures. This means that you should develop your own policies for sending and subsidizing your employees' attendance at professional meeting and events.

Once these procedures are written into your SOPs, they also provide a framework for ALL employees. They also serve as evidence if you ever find yourself in a legal conflict.

CONCLUSION

In studies conducted by the Medical Group Management Association and others, it has repeatedly been shown that practices lose money not because of failures in medical care, but because of inadequate policies, procedures, and oversight.

Although it takes time and energy to implement standard operating procedures, systems, and training, the benefits are real, and they will show up on your bottom line.

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